ASIIS Enrollment Form
Web Based Application for Health Workers/CPS
(602) 364-3899 or 1-877-491-5741 (toll-free number)
(602) 364-3285 (ASIIS fax number)
(View Privilege Only)

Directions: Please fill out completely including a signature by an authorized representative. **Each user needs to fill out a Pledge to Protect Confidential Information form.**

Facility Name & District: _____

Contact Name: _____

Address: _____

City: _____State: _____   Zip Code: _____

Phone#: _____   Fax #: _____

E-Mail Address: _____

Please Note: Internet Explorer 6.0 is required for use of the web application. Internet Explorer is available at www.microsoft.com.

ASIIS is a computer based immunization registry and tracking system implemented by the Arizona Department of Health Services and its partners. It is intended to aid health care professionals and other users who have a need to check a client's immunization status according to A.R.S § 36-135, R9-6-707, and R9-6-708. Client-specific information is only available to authorized users and the Arizona Department of Health Services. As a condition for participation in ASIIS, the User enters into this agreement with the Arizona Department of Health Services.

1.   User agrees to use ASIIS only for the immunization needs of User's clients. User and his/her personnel will access the registry system only when needed to provide health care for User's client(s) or to assess overall immunization status.
2.   User is responsible for the actions of User's staff regarding the confidentiality of information contained in the registry system. User shall adhere to the requirements in the ASIIS Confidentiality Policy, which is incorporated by reference into this agreement.
3.   User agrees that he/she will safeguard his/her User ID and password against use other than allowed by this agreement. This agreement is in effect for one year and will need to be _**renewed annually**_.
4.   User shall give ASIIS the demographic and immunization information on clients for whom permission has been obtained. User shall submit the immunization information to ASIIS within 30 days of the administered vaccination.
5.   User shall allow the parent or guardian to inspect, copy, and if necessary, amend or correct their own children's immunization records. The parent or guardian must demonstrate with proof of a signed official immunization record prior to the information being entered into the user's database and sent to ASIIS.
6.   User will use the Web Application (direct access to the registry via the internet) to look up records on the ASIIS Registry.

List all the Staff who need Web Access	
1.	5.
2.	6.
3.	7.
4	8.

This agreement is effective January 1st of the current year or when signed and received by the Arizona Department of Health Services, ASIIS program at 150 North 18th Ave, Room 120, Phoenix, Arizona 85007-3233. ASIIS Technical Support Line (602) 364-3899 or 1-877-491-5741 (toll-free).

X_____   **X**_____

Authorized Representative   Date

Revised January 2013

ARIZONA DEPARTMENT OF HEALTH SERVICES

PLEDGE TO PROTECT CONFIDENTIAL INFORMATION

I, _____understand and agree to abide by the following statements addressing
      (Please Print Name)
the creation, use and disclosure of confidential information, including information designated as
protected health information ("PHI"), and all other sensitive information:

1.   I understand that as a user of information at the Arizona Department of Health Services, I may develop, use, or maintain information relating to public health and welfare, direct or indirect health care, quality improvement, peer review, audit functions, education, billing, reimbursement, administration, research or other approved purposes. This information, from any source and in any form, including, but not limited to paper records, oral communications, audio recordings and electronic display, is considered confidential. Access to confidential information is permitted only on a need-to-know basis and limited to the minimum amount of confidential information necessary to accomplish the intended purpose of the use, disclosure or request.

2.   I understand that it is the policy of the Arizona Department of Health Services that users (i.e., employees, medical staff, students, volunteers, contractors, vendors and others who may function in an affiliated capacity) shall respect and preserve the privacy, confidentiality and security of confidential information.

3.   I understand that persons who have access to information that contains confidential information are ethically and legally responsible for observing the federal and state statutes and rules governing confidential records. I will not alter, misuse, disclose without proper authority or the individual's authorization any confidential information.

4.   I understand that confidential information may include oral communications, paper or electronic documents, databases, audio/visual tapes, and other items identified as "confidential" or "sensitive" information.

5.   I understand that Arizona State Law prohibits me from using confidential information for personal gain.

6.   I understand that confidential information in my control must be maintained and protected from inappropriate disclosure at all times (i.e., hard copy information when not in use will not be accessible to others, including stored in locked or other secure compartments, computer files must be password protected and closed, working documents turned face down on desk, electronic transmission of information will be encrypted according to Department policy, etc.)

7.   I understand that it is the user's responsibility to protect highly sensitive Department information. As such, I am required to use good judgment in assessing what form of communication is appropriate for particular information. If I have any questions or concerns, I am to consult Department policies, my supervisor or the applicable Assistant Director for guidance.

8.   I understand that confidential information may only be accessed when I am specifically authorized to do so by the appropriate program manger and I will use only the amount of information necessary within the scope of my duties. When confidential information is no longer needed, I will dispose of it in an appropriate manner to prevent inappropriate access to that information.

9.   I understand that confidential information, including paper and electronic records, correspondence, documents and other forms of such information, cannot be released to or discussed with anyone other than authorized individuals. I will also violate this provision if I intentionally or negligently mishandle or destroy confidential information.

10.   I understand that I am not to contact the individuals(s) or other related persons to whom confidential information pertains unless I am specifically authorized to do so by law and the appropriate program manager.

11.   I understand that it is a violation of Department and State of Arizona policy for me to share my sign-on code and/or password for accessing electronic confidential information or for physical access to restricted areas. I further understand that I will not use another person's sign-on code and/or password or otherwise attempt to access electronic confidential information or to gain physical access to a restricted area that is not within the scope of my work or permitted by my supervisor.

12.   I understand that it is my responsibility to know and abide by any additional confidentiality provisions required by my job that may be issued by the Department, Division, Bureau, program or other work unit to which I report. If I have questions about which confidentiality rules apply to my job, I understand that it is my responsibility to ask my supervisor prior to releasing any information, even if the information request is in the form of a subpoena or other legal document.

13.   I understand that it is my responsibility to report any observed or suspected breach of confidentiality by any other Department employee to my supervisor.

14.   I understand that if it is determined that I have violated this Pledge or any other confidentiality requirement, I may be subject to formal disciplinary action up to and including termination of employment, loss of privileges, contractual or other rights which may be granted as a result of an affiliation in accordance with Department and/or State of Arizona procedures. Unauthorized use or release of confidential information may also subject me to personal, civil, and/or criminal liability and legal penalties.

SERVICE DESIGNATION: ☐ Employee ☐ Contractor ☐ Volunteer ☐ Student ☐ Other _____

_____   _____   _____
        Signature   Title   Date